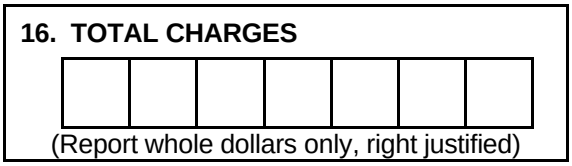
TOTAL CHARGES — Section 97230

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), report Total Charges for the last year (365 days) of stay only.

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission for discharges occurring on or after January 1, 2006:



Reporting Requirements:

When there are no charges (**no bill generated**) for the hospital stay, $1 should be reported.

Charges should be rounded to the nearest dollar.

Charges for newborns must be reported on the newborn's discharge data record and excluded from the mother's discharge data record.

Total Charges are the amount billed for the stay at full established rates (before contractual adjustments).

Examples of charges to be **included**:

Daily hospital services
Ancillary services
Other services defined as patient care
Prepayments (e.g., deposits and prepaid admissions)
Bundled ambulatory surgery, outpatient, and/or observation charges
Late revenue adjustments

Examples of charges to be **excluded**:

- Hospital-based physician fees
- Medicare bed hold charges for skilled nursing care
- Television
- Telephone
- Guest trays
- Take-home drugs
- Video cassette recorder
- Follow-up home health visits

Patient Length of Stay:
This is calculated by subtracting the Admission Date from the Discharge Date. A patient admitted and discharged on the same day is calculated as one day.

Patient Charges per Day:
This is calculated by dividing the reported Total Charges by the Length of Stay.

Length of Stay Greater than 365 Days:

Only total charges for the final 365 days are to be reported.

OSHPD divides reported total charges by 365 to find the average charge per day. This average charge per day is then multiplied by the length of stay. The result is the adjusted total charges, which is the amount appearing in OSHPD publications.

Seven Digit Format: OSHPD's standard format and specifications for reporting total charges requires seven digits (0000000 through 9999999); this allows a maximum charge for one patient of $9,999,999. If the field size is less than seven digits, a total charge of $99,999 or $999,999 indicates to OSHPD that the charges exceed the field size utilized by the hospital or designated agent.

Physician Professional Component:
When the hospital bills patients for physician services and remits a fee to the physician, whether the fee is in the form of a salary or a percentage of the total charges, the fee must be excluded from total charges. This is necessary in order to obtain comparability of charge data on all hospitals.

Total Charges: Each episode of inpatient care must be reported.

Patient's Charge per Day: This is calculated by dividing the reported Total Charges by the Length of Stay

Transfer Within the Hospital:
Transfers between Types of Care Within the Hospital must be reported to OSHPD as two or more separate discharge data records, including separate total charges.

Total Package:
A person admitted for a course of treatment (e.g., for psychological problems, substance abuse treatment, treatment of an eating disorder) is told that the payment covers the total package for all treatments and any later need for inpatient care for the same purpose (within a certain period of time). After the patient is discharged, a discharge record must be reported. If the patient is readmitted, another discharge record must be reported when the patient leaves the hospital, even if no additional charge will be made to the patient. The second and any subsequent record for this course of treatment would report total charges of $1 (no charge) to OSHPD.

Live Organ Donors:
When a (live) person is admitted for the purpose of donating an organ, a discharge data record must be reported whether or not a charge is made. If no charge is made, report total charges of $1 (no charge).

Interim Billing:
Some hospitals have a policy, for billing purposes, of discharging and readmitting their extended stay patients at the end of each month. Only one discharge data record must be reported to OSHPD. That one record must include charges for all days of inpatient care.